IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

JANE DOE, a minor, by her parents and next friends, JOHN DOE and JILL DOE, Plaintiff, v. ELKHORN AREA SCHOOL DISTRICT; JASON TADLOCK, in his individual capacity; RYAN MCBURNEY, in his individual capacity, Defendants.	No. 2:24-cv-00354-JPS

EXPERT WITNESS DECLARATION OF DR. STEPHANIE L. BUDGE, PH.D.

I, Stephanie L. Budge, Ph.D., hereby declare as follows:

1. I submit this expert declaration based on my personal knowledge.

2. I am a licensed psychologist specializing for over 16 years in issues of gender identity, gender transition and, in particular, the mental health of transgender individuals and the treatment of gender dysphoria. I am a professor in counseling psychology at the University of Wisconsin-Madison.

3. I have been retained by counsel for the plaintiff in the above-captioned matter to provide expert opinions about: (a) the psychological understanding of gender identity and what it means to be transgender, (b) gender dysphoria and its treatment, including social transition, (c) the importance of access to sex-separated facilities as a part of social transition, (d) the harms caused by excluding transgender students from using sex-separated facilities that are aligned with their gender identity, (e) misinformation about transgender individuals' use of restrooms

consistent with their gender identity, and (f) the plaintiff's mental health and the relationship of her mental health to not being able to use the girls' restroom at school.

I. QUALIFICATIONS

4. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and accurate copy is attached as Exhibit A to this declaration.

5. I received a master's degree in educational psychology from the University of Texas at Austin in 2006 and a Ph.D. in counseling psychology in 2011 from the University of Wisconsin-Madison. My Ph.D. concentration specifically focused on transgender individuals' mental health. I also specialized in psychological assessment as part of my Ph.D. degree program.

6. I have been a mental health professional since 2006, and I am currently licensed to practice psychology in the state of Wisconsin (license # 3244-57). I have been a professor in counseling psychology at the University of Wisconsin-Madison since 2014.

7. I have extensive expertise working with transgender people–those whose gender assigned at birth is different from their gender identity. I have been a mental health provider to transgender individuals since 2007. Transgender individuals have comprised the majority of my clinical caseload since 2011, and I have worked clinically with approximately 200 transgender patients through the provision of individual therapy, group therapy, psychological evaluations, and supervision of others' clinical work. A significant portion of my clinical work has focused on adolescents and young adults. For example, I held an appointment as a clinical health psychologist at UW Health Pediatric and Adolescent Transgender Health (PATH) clinic, where I conducted clinical assessments with transgender adolescents ages 13-18. I have also facilitated

clinical support groups for transgender adolescents ages 14-18 at the Counseling Psychology Training Clinic (CPTC) at the University of Wisconsin-Madison, and I provided psychotherapy to transgender adolescents in when I had a private practice.

8. As a faculty member at UW-Madison, I teach courses that focus on training master's and doctoral students to become mental health professionals and psychological researchers. I provide pro bono clinical services and train student therapists in best practices in clinical work with transgender patients at the Counseling Psychology Training Clinic (CPTC), the community clinic affiliated with my academic department at UW-Madison.

9. As part of my faculty appointment, I am the Director of the Transgender Counseling Advocacy Research and Education (CARE) Collaborative. In this role, I design research projects that focus on the mental health needs of transgender individuals. One of the current research projects is an open clinical trial focusing on the effectiveness of psychotherapy for transgender individuals. As part of this clinical trial, we trained over 100 mental health providers on how to reduce distress that is experienced from discrimination by other individuals or entities, and 49 patients were enrolled in and received psychotherapy as part of the trial. While some of the research we conduct is with adults, we engage in a large body of research that focuses on transgender adolescents. Specifically, we have recently conducted and presented analyses from the Trans Teen and Family Narratives project, and we finalized publishing our sixth and final article from the longitudinal Transgender Youth and Families Study in 2023.

10. I have published 109 invited and peer-reviewed journal articles and book chapters, with the majority of these focusing on transgender individuals. Notably, several of these publications are focused on the impact of discrimination on transgender youth and adults' mental health and effective interventions to improve transgender youth and adults' mental health.

I have been involved in more than 200 academic presentations (internationally, nationally, and regionally). The majority of these presentations have been focused on transgender individuals, with a significant proportion focusing on transgender adolescents under the age of 18.

11. I am an associate editor for the journal *Psychology of Sexual Orientation and Gender Diversity*. I am on the editorial board for the *International Journal of Transgender Health* as well as *LGBTQ+ Family: An International Journal.* Researchers in the United States and across the world regularly seek my assistance as an expert reviewer for research focused on transgender individuals.

12. I have received several awards for my work in the science and clinical practice of working with transgender individuals. I received the 2021 American Psychological Association Distinguished Contribution to Counseling Psychology Award for my clinical work and research with transgender people. I also received the 2021 American Psychological Association Social Justice Award for my contributions to psychotherapeutic practice with transgender people. I was the first recipient of the American Psychological Association Transgender Research Award in 2010. For my community-focused research, I received the UW-Madison School of Education 2018 Community Engaged Scholar Award, the 2021 UW-Madison Exceptional Service Award, and the 2022 UW-Madison School of Education Excellence in Diversity Award.

13. I am a member of the Society for the Psychology of Sexual Orientation and Gender Diversity (the "Society") within the American Psychological Association ("APA"), of which I am also a member. In August 2021, I completed a 10-year term as co-chair of the Science Committee for the Society and continue as a member of this committee. We provide programming at the APA annual convention to disseminate cutting edge research on the best psychological practices and evidence-based treatments for lesbian, gay, bisexual, transgender,

and queer ("LGBTQ+") individuals. At the 2022 APA annual convention, I chaired or participated in six presentations and panels that focused on best practices in psychological science regarding transgender populations and interventions to reduce psychological distress for transgender individuals; in August 2024 I will be engaged in similar science-based discussions at the APA annual convention. In 2021, I became a Fellow of the APA.

14. In addition, I am a member of the World Professional Association of Transgender Health ("WPATH"). WPATH is an interdisciplinary professional organization of individuals worldwide specializing in research and practice in transgender health. WPATH publishes the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, which are widely accepted by health care practitioners across disciplines who provide care to transgender individuals.

15. I am being compensated at an hourly rate of $250/hour for actual time devoted for research, preparation, reports, consulting, and deposition/testimony related to my expert opinion in this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

16. In the previous six years, I have testified as an expert at trial or by deposition in *Boyden v. Conlin*, No. 17-cv-264 (W.D. Wis.); *Cooper v. USA Powerlifting*, No. 62-CV-21-211 (Minn. Dist. Ct.); and *Roe v. Critchfield*, No. 1:23-cv-315 (D. Idaho).

17. In preparing this expert declaration, I reviewed Plaintiff Jane Doe's complaint, motion for preliminary injunction, memorandum of law in support of the plaintiff's motion for preliminary injunction, the declaration of John Doe, Jane Doe's Gender Support Plans (2022-2023; 2023-2024), Jane Doe's academic grade reports, Jane Doe's Section 504 evaluation and draft plan, and mental health documents related to Jane Doe. My opinions are based on my

education; my clinical experience; research findings from my own scholarship; and my review of the seminal and most influential psychological and public health research on transgender individuals, including the most current research published as recently as this year. Attached as Exhibit B is a bibliography of the relevant and pertinent medical and scientific literature relating to the opinions expressed in this expert report. The materials I have relied upon in preparing this expert report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on these subjects. I reserve the right to supplement these opinions based on subsequent developments in my field and/or factual developments in this litigation.

II. BACKGROUND INFORMATION ON GENDER IDENTITY AND GENDER DYSPHORIA

18. The term "gender identity" is a well-established concept in psychology and medicine, referring to a person's internal or psychological sense of having a particular gender. All human beings have a gender identity. People usually begin to explore and understand their gender identity around the age of three (with some variation), although some transgender individuals may not begin to recognize or express their gender identity until later in life.

19. At birth, the sex of infants is typically assigned as male or female based on external genitalia. Typically, individuals born with the external physical characteristics commonly associated with males identify as men and experience themselves as male, and individuals born with the external physical characteristics commonly associated with females identify as women and experience themselves as female. However, for transgender individuals, this is not the case. For transgender individuals, their internal sense of their own sex—that is, their gender identity—differs from the sex they were assigned at birth.

20. Every individual's sex is multifaceted and composed of many distinct biologically influenced characteristics, including, but not limited to, chromosomal makeup, hormones,

internal and external reproductive organs, secondary sex characteristics, and gender identity. Where there is a divergence between these characteristics, gender identity is the most important and determinative factor in determining one's sex. Scientific and medical research demonstrates the influence of biological factors to gender dysphoria—most notably, an atypical interaction of sex hormones with the developing fetal brain (Sadr et al., 2020), genetic factors (Ashley & Harley, 2023), and brain development (Rouse & Hamilton, 2021; Sanchez & Pankey, 2017; Spizzirri et al., 2018). Using a term such as "biological sex" is inaccurate, because there are a multitude of factors that contribute to one's sex.

21. Unlike cisgender (people whose assigned sex at birth is aligned with their gender identity) children and adolescents, transgender children and adolescents experience a pervasive, consistent, persistent, and insistent sense of being a sex different from the sex assigned to them (*e.g.*, Olson et al., 2015; Rafferty et al., 2018).

22. For many people who experience incongruence between their gender identity and their sex assigned at birth, the incongruence can cause serious emotional distress.

23. Gender dysphoria, currently codified in the American Psychiatric Association's (2022) Diagnostic and Statistical Manual of Mental Disorders ("DSM-5-TR"), is the psychiatric diagnosis for the distress associated with gender incongruence; this diagnosis was first recognized in the DSM-5 (APA, 2013). Individuals who are diagnosed with gender dysphoria can experience a number of different symptoms. When individuals with distress related to gender incongruence are unable to live consistently with their gender identity and do not obtain competent and necessary treatment (which may include a social transition and medical treatments), serious and debilitating psychological distress (for example, suicidal ideation, substance use, depression, anxiety, and self-harm) often occurs.

24. Under the DSM-5-TR, there are two criteria used for diagnosing gender dysphoria in adults and adolescents (F64.0), Criteria A and B. The symptoms under Criterion A for identifying gender dysphoria include a marked incongruence between one's experienced/expressed gender and one's assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

(1) A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics);

(2) A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics);

(3) A strong desire for the primary and/or secondary sex characteristics of the other gender;

(4) A strong desire to be of the other gender (or some alternative gender different from one's assigned gender);

(5) A strong desire to be treated socially as the other gender (or some alternative gender different from one's assigned gender); and

(6) A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

25. According to the DSM-5-TR Criterion B, a diagnosis of gender dysphoria also requires a finding of clinically significant distress or impairment in social, occupational, educational, or other important areas of functioning.

26. To receive a diagnosis of gender dysphoria, a licensed medical or mental health provider will conduct an intake and health history of a patient and will ask questions that focus on the diagnostic criteria for gender dysphoria. The diagnosis is most often provided based on a diagnostic interview where a highly trained clinician asks questions derived from a diagnostic manual, and, if a minor, with the patient's parents present; some providers may also use psychological assessment tools that focus on gender dysphoria.

27. Transgender identity is not synonymous with a gender dysphoria diagnosis, but most transgender adolescents will meet criteria for a gender dysphoria diagnosis. Transgender adolescents may not have a formal diagnosis of gender dysphoria for several reasons, including a lack of access to a medical provider, stigma-related anxiety, and families adjusting to a social transition prior to seeking mental health care or medical support. In a recent study, out of 5,637 transgender adolescents, 2/3 of the sample had not disclosed their gender identity to medical professionals, and younger transgender adolescents (ages 13-14) disclosed even less to medical professionals (McKay & Watson, 2020). Wagner et al. (2021) note that there are significant barriers to receiving a gender dysphoria diagnosis for transgender adolescents, with the data indicating that there were disparities for transgender girls to receive the diagnosis when compared to transgender boys. Youth who were ages 10-14 were also less likely to receive a gender dysphoria diagnosis.

28. The World Professional Association for Transgender Health ("WPATH") publishes the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People ("WPATH SOC") (Coleman et al., 2022), which are widely accepted protocols for the treatment of gender dysphoria. These standards are developed by the foremost

experts in the field of transgender health based on systematic review of the evidence-based research on transgender health.

29. WPATH has published several iterations of the WPATH SOC since 1979. The eighth and most current version of the WPATH SOC was published in 2022. Every major medical organization within the United States, including the American Medical Association, American Psychological Association, American Psychiatric Association, and the Endocrine Society, endorses the WPATH SOC as the prevailing standards of care for working with transgender adolescents.

30. According to the WPATH SOC, providers working with adolescents or children presenting with gender dysphoria should have: a) at least a master's degree or its equivalent in a clinical behavioral science field, b) competence using the DSM-5-TR or the International Classification of Diseases (ICD), c) the ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria, d) documented supervised training and competence in psychotherapy or counseling, e) knowledge about gender non-conforming identities and expressions and the assessment and treatment of gender dysphoria, and f) regular continuing education in the assessment and treatment of gender dysphoria. In addition to these components, it is necessary for providers to have specialized training in child and adolescent development, with a specific emphasis on assessment and diagnosis/psychopathology for children and adolescents.

31. Under the WPATH SOC, effective treatment of gender dysphoria often includes social transition. The term "social transition" refers to the process a transgender person undergoes to live in the world in a manner consistent with the individual's gender identity. The WPATH SOC also provide that for some adolescents and adults, medical interventions to align

the individual's body with their gender identity may be indicated. Treatment is individualized based on the needs of the patient and the patient's age.

32. For transgender people, social transition can be an important aspect of treatment to reduce the symptoms of gender dysphoria. As part of a social transition, an individual will typically, among other things, use a name and pronouns congruent with their gender identity, dress and present in a manner typically associated with their gender identity, and use sex-designated facilities such as restrooms that align with their gender identity. To be clinically effective at alleviating the distress associated with gender dysphoria, a social transition must be respected consistently across all aspects of a transgender individual's life—for example, at home, in school, and at work.

33. Most transgender adolescents will undergo some type of social transition as part of their gender transition. Youth who do not move forward with a social transition are often prevented from doing so due to external factors, such as unsupportive caregivers or lack of safety (*see* Ehrensaft et al., 2018). Current evidence-based treatment protocols indicate that when a transgender adolescent socially transitions, mental health and medical providers and social supports should affirm the adolescent's gender identity to ensure that their gender identity is part of their lived experience in all aspects of their lives. It is the aim of treatment to assist the children and adolescents in successfully integrating their internal identity into a life that allows them to function consistently in accordance with that identity and not feel shame for who they are.

34. For those transgender adolescents for whom social transition is part of their treatment of gender dysphoria, it is likely that serious distress will result if clinically indicated aspects of transition are impeded. *See infra* ¶¶ 56-58.

35. Psychotherapy to reduce the harmful effects of stigma and improve resiliency can also be an important form of support for transgender individuals of any age with gender dysphoria. While psychotherapy can be useful as a support tool, it is not a substitute for social transition and clinically indicated medical transition as a means to reduce or eliminate gender dysphoria.

III. DISCRIMINATION AGAINST AND VICTIMIZATION OF TRANSGENDER INDIVIDUALS

36. Excluding transgender boys from using facilities used by other boys, and transgender girls from using facilities used by other girls, subjects these youth to discrimination in a context in which they already experience a disproportionate amount of discrimination and adverse health impacts that result from discrimination.

37. Psychological science has used the concept of "minority stress" to understand and explain the reasons why transgender people (and members of other minority groups) experience physical and mental health disparities. The minority stress model indicates that there are three types of minority stressors: 1) external stressors, 2) expectations of external stressors, and 3) internal stressors. Examples of external stressors experienced by transgender people include discrimination, prejudice, harassment, rejection, and non-affirmation of gender identity. Examples of internal stressors experienced by transgender people include concealing one's gender identity, internalizing gender-related stigma, and constantly thinking about one's gender. Transgender people will often expect that they will experience external stressors due to having actually experienced them in the past, as well as witnessing or hearing about other transgender people who have experienced external stressors.

38. In addition to studies that focus generally on external stressors, there have been several studies that delve into specific types of external stressors. For example, there is one type

of external stressor called “misgendering” that includes communications or actions that convey that a person’s gender is misperceived or is being purposefully denied. Examples of misgendering can include using a name or pronouns inconsistent with a person’s gender identity or denying them access to gendered facilities that are consistent with their gender identity (McLemore, 2018). McLemore (2015) found that experiences of being misgendered were associated with anxiety and negative affect (*e.g.*, hostility and guilt), lower self-esteem related to appearance, and felt stigma. In a follow-up study with more specific measures regarding mental health, McLemore (2018) again reported that experiences of being misgendered were related to depression, anxiety, stress, and felt stigma.

39. Misgendering, along with other forms of external stressors, is considered a form of social exclusion. Social psychology has established that seeking social acceptance is one of the most basic human needs and that the harms of social exclusion based on identity are widespread and can be catastrophic. On an individual level, social exclusion impacts one’s sense of belonging, self-esteem, sense of existence, and self-control. Social exclusion is associated with an increase in maladaptive behaviors and risk-taking behaviors. On a systematic level, social exclusion is often reinforced by organizations and institutions adopting policies and procedures that can enforce discrimination toward certain groups of people. Social exclusion is considered harmful in general; however, it can be even more harmful when people in positions of power perpetuate notions that isolate and stigmatize transgender people. Research on social identity theory describes the harm that results when people of higher status—usually people in power such as administrators—fail to affirm or actively disaffirm lower-status individuals with a marginalized identity (Hogg, 2016). This often leads to external forms of harm such as ostracization and discrimination against the individual by peers and others, as well as internal

harms such as internalized shame and self-hatred. These internal and external factors can be directly related to psychological distress, such as post-traumatic stress disorder, depressive disorders, anxiety disorders, and hypertension, amongst myriad other health concerns.

40. In a study involving 610 transgender individuals (Galupo et al. 2020), study participants provided information about their experience of gender dysphoria. When asked about the impact of being misgendered or otherwise discriminated against based on their being transgender, they provided descriptions such as "it's like a visceral, violating, physical manifestation of psychological pain for me" and "each of those [misgenderings] is a knife."

41. There is a large body of scientific data indicating that transgender people experience a significant number of external stressors. The U.S. Transgender Survey (James et al., 2016), collected data regarding discrimination experiences of 27,715 transgender people aged 18 and above in the United States. This dataset concluded that transgender people experience substantial discrimination through a multitude of contexts, including employment, education, facilities, housing, legal protections, and access to health care services. Follow-up studies using the same nation-wide dataset indicate that experiences of transgender-related harassment in K-12 school environments primarily accounts for negative mental health experiences of transgender students, and that if students socially transition, the positive mental health effects from the social transition can act as a protective factor from the effects of harassment in those environments (Turban et al., 2021).

42. In their systematic review of discrimination experiences reported by transgender people, McCann & Brown (2017) found that for 19 studies including over 9,000 participants, experiences of transgender-specific discrimination ranged from 40-70%, depending on the type of discrimination (e.g., health care discrimination, harassment, violence). However, more recent

estimates indicate the numbers might be higher than in the 2017 review. In a study my colleagues and I recently conducted with a sample of 575 transgender participants, 92.6% reported at least one lifetime experience of transgender-related discrimination (for example, not being treated fairly or justly in specific environments), 94.2% reported at least one lifetime experience of anti-transgender rejection (for example, relationships ending or feeling unwelcome in certain communities), and 78.9% reported at least one lifetime experience of anti-transgender victimization (for example, experiences of physical harm, harassment, or property damage) (*see* Barr, Snyder, Adelson, & Budge, 2021). Also, in a recent study focusing on discrimination experiences of transgender people, 76.1% of the sample reported experiencing discrimination in the past year (Puckett et al., 2020).

43. In addition to experiences of discrimination, transgender people report extensive exposure to mistreatment, harassment, and violence (James et al., 2016). One of the largest nationwide studies in the United States focused on LGBTQ+ youth demonstrates that transgender youth experience significant amounts of harassment, bullying, and violence (Kosciw et al., 2022). In a report from the data that compared transgender and cisgender youth (GLSEN, 2021), 84.4% of transgender youth felt unsafe at school when compared to 20.6% of their cisgender LGBQ+ (lesbian, gay, bisexual, and queer, but not transgender) peers. In addition, 43.6% of the transgender sample reported missing school because they felt unsafe or uncomfortable, compared to 24.9% of their cisgender LGBQ+ peers. The study indicated that 77.3% of transgender students reported experiencing discrimination at school, compared to 46.1% of the cisgender sample. In the overall report (Kosciw et al., 2022), 80.3% of youth reported hearing biased language regarding gender expression and 65.2% reported hearing anti-transgender language while at school. Of those youth, 72% reported that there was a staff

member present while hearing those remarks and that 91% of staff did not intervene. In one of the largest nationwide Canadian studies to focus on transgender youth (Taylor et al., 2020), 66% of youth reported being bullied, 35% were physically threatened or injured, 9% were threatened with a weapon; 63% reported experiencing verbal sexual harassment, 34% reported physical sexual harassment.

44. Transgender children and adolescents experience a great deal of victimization in the school environment, including bullying, physical assault, sexual assault, maltreatment, property victimization, and witnessing/indirect victimization. In their systematic review, Martin-Castillo et al. (2020) examined the effects of school-based victimization throughout 19 studies covering over 23,000 transgender people. Results from this systematic review indicate that transgender youth experience significantly higher rates of victimization at school than their cisgender peers.

45. There also is robust data regarding the psychological impact of external stressors for transgender youth and young adults. Exposure to discrimination has been linked with higher reports of depression, anxiety, post-traumatic stress disorder, self-harm, and suicidality (e.g., Chozden et al., 2019; Price-Feeney, Green, & Dorison, 2020; Veale et al., 2019; Wilson et al., 2016). In a recent study, Pease and colleagues (2022) note that external minority stressors were directly related to psychological distress for young adults. In addition to this finding, they also note that experiencing more anti-transgender discrimination leads to higher levels of gender dysphoria, which then increase psychological distress for young adults.

46. Regarding mental health disparities, transgender youth consistently report higher instances of mental health concerns when compared to their cisgender counterparts. When compared with cisgender matched controls, transgender youth displayed a twofold to threefold

increased risk of depression, anxiety, suicidal ideation, suicide attempt, and self-harm (Reisner et al., 2015). In their study, Fox et al. (2020) report that transgender adolescents were 8 times more likely to report depressive symptoms when compared to cisgender adolescents and were 5 times more likely than cisgender adolescents to report self-harm and suicidality. There is a large body of research demonstrating that these disparities can be explained primarily by the presence of external stressors. One study by Suarez et al. (2024) analyzed data comparing 98,174 cisgender and transgender youth and found that transgender students were more likely than cisgender students to report experiences of violence, poor mental health, suicide risk, some sexual risk behaviors, unstable housing, and felt less belonging at school.

47. Although all psychological distress deserves attention, suicidality (suicidal ideation, suicide attempts, and completed suicide) is perhaps one of the most devastating outcomes due to the finality of completed suicide. For transgender youth, the evidence indicates that suicidality is an overwhelming mental health disparity. For example, in a sample of transgender youth, 86% reported suicidal ideation and 56% reported a previous suicide attempt and that external stressors such as harassment and bullying were directly related to suicide attempts (Austin et al., 2022). Data indicate that transgender youth are 2.71 times more likely to attempt suicide when compared to cisgender youth (Jackman et al., 2019). As noted above, these disparities can be explained primarily by the presence of external stressors.

48. Studies demonstrate that a negative school climate is not only detrimental to transgender youths' mental health, but also impacts their academic achievement. When compared to cisgender youth, transgender youth were three times more likely to be truant from school due to feeling more unsafe and distressed (Day et al., 2018). Additionally, transgender youth reported

greater victimization at school and poorer academic performance when compared to cisgender LGBQ+ peers (Poteat et al., 2021).

IV. THE IMPACTS OF EXCLUDING TRANSGENDER STUDENTS FROM FACILITIES THAT MATCH THEIR GENDER IDENTITY

49. In the United States, school and other public multiple occupancy restrooms and locker rooms are typically separated based on gender (women's and men's or girls' and boys' restrooms and locker rooms), unlike most other spaces.

50. When facilities are gendered and a transgender individual is prohibited from using facilities consistent with their gender identity, a variety of negative consequences can result, each of which can lead to adverse mental and/or physical health for the excluded transgender person. These include: (1) feelings of rejection, invalidation, isolation, shame, and stigmatization; (2) interference with the process of social transition; (3) disclosure that the individual is transgender to others who may not know that (and to whom the individual does not wish to disclose that); (4) communication to others of a view that the transgender individual does not belong in spaces used by their peers and that there is something wrong with the individual, which can foster additional discrimination, harassment, and even violence; (5) efforts to avoid going to the restroom, including restricting intake of fluids and food, which can cause serious physical illness; and (6) reduction in the ability to concentrate and learn. In addition, when "accommodations" are offered to transgender individuals that require them to use a separate restroom that is not usually designated for their group (*e.g.*, sending a high school student to a faculty or nurse's restroom) or when a transgender person is told that they—but not their peers—must use a single-user restroom, that individual is being told not only that their gender identity is invalid, but that they are something "other" and must be separated from all their peers because of who they are. Numerous research studies have confirmed the negative psychological impact of

being invalidated and "othered" in these ways (*e.g.*, Price-Feeney et al., 2021; McGuire et al., 2022; McLemore, 2015; McLemore, 2018).

A. Excluding students who are transgender from facilities that are consistent with their gender identity worsens the already severe discrimination experienced by transgender people, contributing to negative health outcomes.

51. Adding to the discrimination transgender youth already experience by excluding them from using the same restrooms and locker rooms as their peers subjects these youth to significant psychological harm and worsens their mental health, including causing feelings of feelings of rejection, invalidation, isolation, shame, and stigmatization, as well as depression, anxiety, and suicidal ideation. Research also indicates that there are cumulative effects of experiencing discrimination, especially related to trauma. In a recent study, my colleagues and I found that the chronicity and accumulation of discrimination events were related to higher incidences of Post-Traumatic Stress Disorder (Barr et al., 2021).

52. Although many transgender individuals report negative consequences when they are restricted from using restrooms consistent with their identity, this exclusion may be particularly damaging during adolescence. Adolescence is marked by a time of development where individuals' attention and awareness are particularly heightened related to looks, "fitting in," and navigating complex social interactions. Transgender adolescents are typically acutely self-conscious of the ways they may be perceived as different from their peers of the same gender. An internal consequence of that "not fitting in" is often internalized shame and sometimes diagnosable social anxiety and depression. External consequences can include experiences of bullying, harassment, and discrimination by peers and adults within school institutions. Of particular concern is bullying and harassment of transgender students, and even

violence against them, if they use restrooms that are inconsistent with how they appear to, or are known to, others.

53. In addition to the links between harassment and discrimination from peers and clinical distress in transgender adolescents, it can be even more harmful when adults in power perpetuate notions that isolate and stigmatize transgender adolescents. Research on what is known as social identity theory describes the harm that results when people of higher status—usually people in power, such as, in the case of students, school administrators—fail to affirm or actively disaffirm lower-status individuals with a marginalized identity. This often leads to external forms of harm such as ostracization and discrimination against the individual by peers and others, as well as internal harms such as internalized shame and self-hatred. These internal and external factors can be directly related to psychological distress, such as post-traumatic stress disorder, depressive disorders, anxiety disorders, and hypertension, amongst myriad other health concerns.

54. Research demonstrates that serious harms can result when transgender individuals are not allowed to use restrooms corresponding to their gender identity (Horne et al., 2022; McGuire et al., 2022; Price-Feeney et al., 2021). Most transgender individuals begin using restrooms consistent with their identity after completing other aspects of social transition (wearing clothing associated with their gender, changing their hair, etc.). Transgender and gender non-conforming people regularly face harassment and victimization in restrooms corresponding with their sex assigned at birth (Herman, 2013). Requiring transgender individuals to use facilities that do not correspond to their gender identity following a social transition thus subjects those individuals to increased risk of actual victimization as well as to the realistic fear of such victimization, with the accordant harms resulting from that stress.

55. Highlighting the harm caused to transgender youth, a recent study by DeChants et al. (2024) indicates that out of a sample of 12,596 transgender youth ages 13-24, 71% of transgender youth report either sometimes or always avoiding using restrooms due to concerns about discrimination. In addition, 67% of youth report "holding it" and 38% indicate that they avoid drinking liquids to avoid using the restroom. Those who avoided bathrooms had twice the odds of attempting suicide in the past year compared with transgender youth who did not avoid using the bathroom. Price-Feeney, Green, and Dorison (2021) note that in a sample of 7,370 transgender youth, 58% reported being prevented or discouraged from using a restroom that corresponds to their gender identity. Of those youth, 85% reported experiencing depression and 60% seriously considered suicide. Statistical analyses indicated that restroom discrimination against transgender youth not only increased depression and thoughts of suicide but was also related to one or more suicide attempts. Additional data indicate that internalizing the impact of legislation restricting restroom use is related to depression and anxiety for transgender people (Horne et al., 2022). A qualitative study of transgender youths' experiences with restrooms by McGuire et al. (2022) indicates that restrictions on the use of gendered restrooms impeded participants from having a good quality of life and impacted how they structured their lives, moved through their days, interacted with others, and envisioned their futures. They also described chronic embarrassment, anxiety, and poor self-esteem specifically tied to fears of harassment and actually experiencing harassment in restrooms that specifically did not align with their gender identity.

B. Excluding transgender students from facilities that are consistent with their gender identity interferes with social transition.

56. Because social transition involves an individual living in the world in a manner consistent with the individual's gender identity, being excluded from facilities consistent with one's gender identity is inconsistent with and will interfere with the process of social transition.

57. Research demonstrates the importance of social transition for transgender youth. Research from the longitudinal TransYouth Project (TYP) indicates that transgender youth who have socially transitioned demonstrate similar mental health patterns when compared to cisgender youth (Durwood et al., 2017; Olson et al., 2016). Additional research demonstrates that social transition processes are related to less depression, less suicidal ideation, less and suicidal behaviors (Russell et al., 2018).

58. Consequently, delaying social transition is detrimental for transgender youth. Horton's (2022) qualitative study of parents of transgender youth provides an in-depth analysis of the consequences of delaying social transition for children, notably mentioning the psychological distress that results from delaying social transition. In the largest nationwide survey in the U.S. focusing on discrimination experiences of transgender people 18 and older, impeding social transition processes (for example, not being able to change one's name) is directly related to experiencing harassment and assault (James et al., 2016). In a large (N = 1,519) nation-wide Canadian survey of transgender youth, findings similarly demonstrate that not being able to access social transition components/processes is also directly related to experiencing harassment, assault, and denial of services (Taylor et al., 2020).

C. Requiring transgender students to use facilities that are inconsistent with their gender identity can disclose to others who would otherwise be unaware that they are transgender.

59. Most transgender individuals begin using restrooms consistent with their identity after completing other aspects of social transition (such as wearing clothing associated with their gender, changing the way they wear their hair, and changing their name and pronouns to be consistent with their gender). Because of that, when transgender individuals who are in the process of social transition are forced to use facilities inconsistent with how their gender is perceived by others or are excluded from facilities used by other students who identify as the same sex as them, this can disclose to others who may not already be aware of the student's transgender status that the student is transgender.

60. There are two primary outcomes from this forced disclosure—one being that transgender youth will experience the psychological distress and gender dysphoria that come from worrying about their gender identity being disclosed without their permission. The second outcome is that transgender youth can become targets for discrimination when their transgender status is made known to others.

D. Excluding transgender students from facilities used by their peers can lead to harassment, bullying, and even violence.

61. When transgender students are excluded from using facilities used by their peers, it does not go unnoticed by other students, who receive the unmistakable message that their transgender classmates are not suitable to be among them. This can encourage other students to engage in harassment, bullying, and even violence toward transgender students (*see* Taylor et al., 2020; Murchison et al, 2019).

62. Requiring transgender individuals to use facilities that do not correspond to their gender identity following a social transition thus subjects those individuals to increased risk of

actual victimization as well as the realistic fear of such victimization, with the accordant harms resulting from that stress.

63. Even when gender neutral restroom options are available, it can be harmful to tell a transgender student that they are required to use those restrooms instead of having the option to use the restroom that aligns with their gender identity. One harm is the increase in gender dysphoria that occurs in adolescents because of being othered by not being able to use the restroom that aligns with their gender identity. Another harm is that if gender neutral restrooms are full and there is a wait for access to these restrooms, there would not be another option for the adolescent (especially in cases of a gastrointestinal emergency).

E. Transgender students excluded from restrooms consistent with their gender identity often take steps to avoid using the restroom, which can have adverse physical consequences.

64. To avoid the harmful effects of non-affirmation or fear of victimization, transgender individuals, including transgender minors, will often avoid using the restroom in any public space, including at school. This can lead to significant health consequences. First, transgender individuals will often avoid an intake of fluids to avoid the necessity to urinate; this can have significant health consequences related to dehydration. Even if transgender individuals do not avoid fluid intake, they will often hold urine in their bladders to avoid using the restroom; this can also cause negative health consequences such as urinary tract or kidney infections. Transgender individuals may also avoid eating certain foods (or restrict food in general) to circumvent defecation, leading to constipation and muscle damage/weakness (*see* James et al., 2016 for data regarding these outcomes).

F. Restricting transgender students from using facilities consistent with their gender identity interferes with their education.

65. Disaffirmation of a transgender student's gender identity, interference with the student's social transition, and anxiety about having their transgender identity disclosed and having to use restrooms inconsistent with the student's gender identity causes emotional harm that interferes with their ability to concentrate, learn, and thrive at school. In addition, reducing fluid and food intake and holding urine in their bladders is psychologically distressing and distracting, making it harder for students to concentrate in their classes and learn. All of this interferes with these students' education and denies them equal educational opportunities. It impairs their ability to develop a healthy sense of self, peer relationships, and the cognitive skills necessary to succeed in adult life. As well, transgender students may stop going to school because of the disaffirmation they are experiencing by not being able to use the restroom that fits their gender identity and subsequent bullying by being outed because of restroom policies at their schools. Pampati et al. (2020) indicate that bullying experiences are associated with absenteeism in school for transgender students; it is well established that chronic absences impact academic achievement (Gottfried, 2019).

V. THERE IS NO EVIDENCE THAT TRANSGENDER INDIVIDUALS' USE OF RESTROOMS CONSISTENT WITH THEIR GENDER IDENTITY HARMS OTHERS.

66. Policies restricting transgender individuals', and in particular transgender youths', access to restrooms that are consistent with their gender identity are frequently sought to be justified by claims that are not supported by the facts. One such piece of misinformation is that transgender people are a threat to the safety of other people when they use restrooms that do not correspond to the sex they were assigned at birth. The evidence does not support this concern (Crissman et al., 2020). This claim is frequently advanced with assertions that a transgender

individual assaulted someone in a restroom when in fact the individual who committed the assault generally is not transgender. The evidence indicates that transgender people are not any more likely to pose a threat to safety in restrooms when compared to cisgender people. In fact, transgender individuals are the ones who are most likely to be assaulted in restrooms (*see* Murchison et al., 2019; Taylor et al., 2020).

67. Another piece of misinformation is that transgender people will expose their genitals to others or engage in "peeking" at others' genitals in public restrooms. Such conduct may be illegal or contrary to school policy, or may subject individuals engaging in it to discipline, for any student that engages in it. Even more importantly, there is no evidence indicating that transgender people are more likely to engage in such misconduct than cisgender people. In my clinical experience discussing restroom safety and perception of threats with transgender patients and community members, transgender people are generally more concerned about their own safety and are focused on their own anxiety and fear when using the restroom. Young people generally exhibit modesty with regard to exposure of their genitals to others, and this is particularly true of transgender young people for whom bringing any attention to their genitals makes them extremely uncomfortable and can increase their experience of gender dysphoria. Gender dysphoria is an uncomfortable and distressing experience, by definition, and transgender people attempt to avoid experiencing it if provided with the opportunity (*see* Galupo et al., 2020).

VII. CLINICAL EVALUATION OF JANE DOE

68. Thus far in this declaration, I have focused on a large body of research that has found a relationship between experiences of discrimination and increases in mental health concerns. This section summarizes the information gathered from the clinical interview and psychological assessment I conducted with Jane Doe and her parents on June 1, 2024, and provides my professional opinion on the effects of the discrimination Jane faced at school on her mental health and overall well-being. I was asked to conduct a psychological assessment of Jane to determine the psychological impact of specific treatment at school based her gender identity and to evaluate the impact of other stressors on her mental health. A full copy of my confidential clinical report, summarized in relevant part herein, is attached as Exhibit C in this report.

A. Relevant background

69. At the time of this report, Jane is 13 and [redacted]ths years old (birthdate: [redacted]). Jane was assigned a male sex at birth. Jane identifies as a [redacted] transgender girl who uses female pronouns (she/her/hers). Jane and her parents indicated that she does not have any physical or cognitive disabilities. In my professional opinion, Jane has a typical developmental history with no remarkable developmental abnormalities. Jane recently completed 7th grade at Elkhorn Area Middle School in Elkhorn, Wisconsin in the Elkhorn Area School District (EASD). She indicates that she used to be a "straight A student" until this most recent term. Ex. B at 3. Jane reported that she loves math, science, art, and music. For hobbies, she said she loves to bake, cook, and play video games; her parents indicated that she also enjoys swimming and hiking.

B. Jane's Gender Identity and Gender Dysphoria Diagnosis

70. Jane was assigned a male sex at birth and was socialized as a boy until she realized she was a transgender girl at the end of 5th grade. She indicated that she had been realizing that she might have a different gender identity than her sex assigned at birth for "a while," mainly noticing that when she dressed in her sister's or mother's clothes and shoes that she would feel a sense of euphoria. Ex. B at 3. Her father, John Doe, noted that he had noticed her gender expression leaning more femininely especially beginning in 3rd grade, where Jane would ask to wear a dress for Halloween or asked for a specific purse, in addition to noticing that she liked to dress up in women's clothing. John stated that Jane began sharing general information about her identity (without using the term transgender) in the summer of 2022. John and Jane's mother, Jill Doe, stated that they were supportive of Jane when they found out about her transgender identity and not surprised to find out about her transgender identity in 2022, since they had noticed her feminine gender presentation in the years prior to learning of her gender identity. Jane and her parents indicated that she started socially transitioning at that time and continued her social transition in 6th grade at her middle school. Jane's parents stated that it was challenging to find a mental health provider for Jane; they said they called multiple therapists and did not hear back from most of them and that there were long wait lists to see providers. They also said that living in a less populated part of Wisconsin made it more challenging for them to find a therapist for Jane.

71. In the clinical interview on June 1, 2024, Jane met 6 out of 6 DSM-5-TR criteria for Gender Dysphoria. Jane stated that she feels an incongruence between her sex assigned at birth (male) and her internal sense of gender identity (female). She indicated that she also experiences this incongruence with her gender expression. She reported that she experiences

dysphoria with the body parts that are typically considered more masculine (facial hair, flat chest, genitals, Adam's apple), with a desire to be rid of these parts. She also indicated that her dysphoria would decrease if she were to grow breasts and ensure that her body hair was typically feminine. She also indicated wishing that her skin was more typically feminine (e.g., softer). She stated that she has a strong need to identify as a girl and realized her female identity toward the end of 5th grade in 2022, when she began to understand her internal feelings of gender that she had been experiencing for quite some time. This timeframe far exceeds the 6-month minimum timeframe listed in the DSM-5-TR criteria for a gender dysphoria diagnosis.

72. Jane noted the importance of others treating her as a girl, as she experiences a great deal of dysphoria when she is misgendered or needs to use restrooms and other school facilities that are gendered male. She stated that she has experienced significant and consistent distress related to being prohibited from using girls' restrooms and how she has been treated by adults and peers at school, which has led to academic consequences (not wanting to attend school; decrease in grades). On the Utrecht Gender Dysphoria Scale, Jane's mean score was 5 on the Dysphoria subscale and was also 5 on the Gender Affirmation subscale, which are the highest scores that one can note on each scale; means from the validation scale ranged from 2.08 to 2.85, noting that Jane's dysphoria is higher than the validation sample.

73. Records from Jane's treating therapist indicate that she diagnosed Jane with Gender Dysphoria in February 2024. It is my clinical opinion that Jane would have been diagnosed with gender dysphoria earlier if she had seen a provider when she first began to disclose her transgender identity. Given the insistence and persistence of her transgender identity since 2022, and the importance of using a restroom aligned with gender identity as part of a social transition process, it was not necessary for Jane to have received a gender dysphoria

diagnosis to be treated as a girl at school either when she first came out at school and was put under a Gender Support Plan in 2022, or at any time since.

C. Psychological Effects of School Discrimination on Jane and Direct Assessment of Harm

74. In addition to confirming the Gender Dysphoria diagnosis, one of the primary themes from the clinical interview was Jane's report of psychological distress that she attributes directly to experiences of discrimination at school. Most significantly, Jane reports suicidal ideation in February 2024 that she attributes to her experiences at school. She also attributes her bulimia nervosa to increases in stress and gender dysphoria which she also links to stress from school. The psychological assessments indicate that Jane's depression and anxiety are rated as severe on standardized tests that compare her to other youth her age.

75. Jane's mental health history indicates a clear correlation of an increase in depression and anxiety that are directly related to her experiences of discrimination at school. Jane's parents shared that they have watched their child go from "absolutely loving school" to watching her say she feels like she is experiencing "hell" at school and can't wait for it to be over. Ex. B at 6. Her mother, Jill, stated that Jane used to wake up excited to go to school and loved talking about what she was learning and that she was very engaged in school activities and with her friends. Her parents said that she has missed more school this year than she has in the rest of her life cumulatively.

76. Jane's experiences with discrimination began in her 6th grade year when she came out as transgender at school and she was told that she was not able to use the girls' restrooms at school. Her father, John, noted that when the Gender Support Plan was first put into place, he and Jill were not provided with any other options for restroom use than what was outlined in the Gender Support Plan, which was for Jane to use the faculty restrooms.

77. Jane indicated that throughout her 6th grade year, she occasionally used the girls' restrooms and was reprimanded for her use of the girls' restroom by school staff. In the clinical interview, she indicated that she did not understand why she was not allowed to use the girls' restrooms and that she has a reduction in gender dysphoria when she is able to use the girls' restrooms.

78. John reported that he and Jane were called to a meeting in August 2023 by the school principal, Ryan McBurney, who reprimanded Jane for using the girls' restroom at school the previous school year. Jane stated that this experience made her feel "extremely anxious and nervous" and led to an increase in gender dysphoria. *Id.* at 7. She stated that this increase in gender dysphoria over the next couple of months eventually led her to having binge eating episodes, which then also resulted in induced vomiting. She also stated that the depression that began at the end of 5th grade worsened when she was restricted from using the girls' restroom at school or admonished because of her use of the girls' restroom.

79. After the meeting with Ryan McBurney in August 2023, Jane indicated that she started to feel more anxious at school and as a result also experienced an increase in depressive symptoms. She stated that she felt as though she was being monitored more closely at school by school staff and that made her feel less welcome at school and would also increase her symptoms of gender dysphoria because she felt othered. As the monitoring continued, she indicated that her bulimia began in December 2023. She indicated that her distress continued to increase through February 2024, where her most significant period of suicidal ideation occurred.

80. Jane reported that she did not go to school for three weeks around March 2024 because she was feeling so anxious about the "fallout at school" from having more visibility around her request to use the girls' bathroom at school. *Id.* She said she would wake up every

day feeling sick with dread. Her parents said that she would not leave her room during this time, except for short periods of time. They said that their compromise to get her to school has been having her go for half days until the school year ends. A combination of medication ([redacted]) and coping skills from therapy have improved her mood enough so that she feels as though she can go to school.

81. Because Jane has missed so much school, she said her grades have suffered. She said that she used to get "straight A's" and really enjoyed doing her schoolwork and now she has trouble concentrating and feeling motivated to do her work. *Id.* Also, since she has missed so much school, she feels like she is behind on the topics and is having trouble catching up on the content.

82. Jane indicated that the more publicity that has gotten out based on how the school is treating her, the worse she has felt regarding her safety. She indicated that not only has it been challenging for the school to not follow federal law regarding gender identity and restrooms, but that after the lawsuit was filed, she began experiencing online bullying where she "saw a lot of transphobia and received death threats." *Id.* She said that this coupled with physical assaults she experienced at school prior to the media reports made her feel as though she could not go to school any longer.

83. Jane stated that an additional consequence of being unable to use girls' restrooms at school is that she has been nauseous at school and had to run past several gendered restrooms and take stairs to make it to the faculty restroom to vomit or have other gastrointestinal distress. John and Jill also noted that Jane's restroom use has been monitored by school staff, which has singled Jane out and led to further feelings of exclusion. Jane reported that she occasionally uses the gender-neutral restrooms at school, but that she often finds that they are unavailable due to

popularity with students at the school and that in more urgent situations she does not have time to wait in line to use the restroom. She also indicated that it increases her dysphoria to wait in line for a restroom when she should be able to use the girls' restroom, but is unable to do so due to the restrictions at her school.

84. In the clinical interview, Jane did indicate that she has experienced an improvement in her wellbeing since starting [redacted] and engaging in therapy; notably that she reports her bulimia nervosa is in remission and that she is able to go to school half days now versus not going at all. Despite these improvements in Jane's well-being, it is unsurprising that Jane maintains clinically significant symptoms of severe depression and anxiety, while also reporting an increase in quality of life. Research indicates that well-being is differentially affected by discrimination, such that negative outcomes (such as anxiety and depression) are twice as harmful as positive outcomes (such as life satisfaction) (Paradies, 2006); a recent meta-analysis confirms a similar finding, while also noting the effects of discrimination are larger on youth (Schmitt, Branscombe, Postmes, & Garcia, 2014).

85. Following my clinical assessment of Jane, I spoke with Jane's treating therapist. Jane's therapist corroborated that Jane is reporting that she is experiencing a boost in mood, but she noted that she continues to see behaviors that demonstrate that Jane is experiencing a significant amount of distress—notably, she stated that Jane's behaviors indicate that she continues to demonstrate social anxiety and withdrawal. Jane's therapist also noted that she has seen the impact of Jane not being able to use the girls' restroom at school. She stated that Jane has felt "singled out" and that makes her feel "less than human." *Id.* at 8. She also noted that she could see the direct result of the discrimination on Jane, in that Jane was missing class and experiencing academic consequences. The therapist also said that she can see that these

experiences have "broken down" Jane's ability to trust others and that as a result, Jane has an "armor up" that makes it difficult for her to connect with others. *Id.*

86. In reading the school's 504 evaluation, it corroborates Chanel's elevated levels of distress that were also displayed in my evaluation for this report. However, these accommodations will not address her experiences of increased distress and gender dysphoria due to being singled out and/or having her restroom use monitored. It is my clinical opinion that if she had girls' restroom access, her distress and dysphoria would likely decrease and that the anxiety that was evaluated for her 504 plan would also decrease as a direct result of being able to use the girls' restrooms at school.

D. Conclusion

87. It is my professional opinion that the Elkhorn Area School District's treatment of Jane Doe and its policies regarding her bathroom use directly caused (and continue to cause) significant psychological distress that places Jane at risk for experiencing life-long diminished well-being and life-functioning. It is my professional opinion that the school district's refusal to allow Jane to use girls' restrooms at school is inconsistent with clinical standards of care for the treatment of Gender Dysphoria and has predictably resulted in emotional, social, and educational harm to Jane.

I declare under penalty of perjury that the foregoing is true and correct.

Stephanie Budge
Stephanie Budge (Jun 17, 2024 18:14 CDT)

Stephanie L. Budge, PhD

Date: Jun 17, 2024